SUSPECT ASEPTIC MENINGITIS CASE INVESTIGATION - Page 1 of 3

Indiana State Department of Health
State Form 51001 (R/5-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Section 2. Clinical Information

Date of Onset / /

Was the patient hospitalized?
- ○ Yes
- ○ No

If Yes, admission date: / /

Discharge date: / /

Hospital:

Patient chart number:

Physician:

Physician phone: - -

Outcome:
- ○ Survived
- ○ Died
- ○ Unknown

Physician's diagnosis:
- ○ Aseptic Meningitis
- ○ Viral Meningitis
- ○ Other

If Other, specify

Indiana State Department of Health
State Form 51001 (R/5-05)

Section 2. Clinical Information (continued)

Symptoms (check all that apply):

- ○ Headache
- ○ Stiff Neck
- ○ Fever ___.___ *(degrees)*
- ○ Malaise
- ○ Rash, describe:
- ○ Nausea
- ○ Flu-like Symptoms
- ○ Confusion
- ○ Coma
- ○ Photophobia
- ○ Vomiting
- ○ Other, specify:

Infant Symptoms (check all that apply):

- ○ Fretfulness or Irritability
- ○ Difficulty in Awakening
- ○ Refusal to Eat
- ○ Fever ___.___ *(degrees)*
- ○ Other, specify:

Section 3. Laboratory

Was cerebrospinal fluid (CSF) obtained?
○ Yes ○ No ○ Unknown **If Yes, date collected:** ___/___/___

If Yes, indicate the results of the following:

WBC: ____ **RBC:** ____
Neutrophils/Polys (%): ____ **Protein:** ____
Eosinophils (%): ____ **Glucose:** ____
Lymphocytes (%): ____

Was virus cultured from the CSF?
○ Yes ○ No ○ Unknown **If Yes, date isolated:** ___/___/___

If Yes, specify virus

Was virus cultured from any of the following specimens?
○ Stool ○ Throat ○ Other

If Other, specify

Were bacteria, fungi, or other non-viral organisms isolated from the CSF or seen on stain?
○ Yes ○ No ○ Unknown

If Yes, specify

Were bacterial, fungal, or other non-viral antigens, antibodies, VDRL or DNA (PCR) detected in CSF?
○ Yes ○ No ○ Unknown

If Yes, specify

SUSPECT ASEPTIC MENINGITIS CASE INVESTIGATION -

Indiana State Department of Health
State Form 51001 (R/5-05)

Section 3. Laboratory (continued)

Was testing done to detect Arboviral Encephalitis infection?

○ Yes ○ No ○ Unknown **If Yes, date performed:** ___ / ___ / ___

If Yes, specimen:

○ Blood ○ CSF ○ Other **If Other, specify:** _____

_____

If Yes, result

Section 4. Other Case Information

Does this patient attend school or a child-care setting?

○ Yes ○ No ○ Unknown

_____

If Yes, name of school/day care

_____

Address

_____ ___ - ___ - ____

Contact Name **Contact Phone**

Did the patient have recent contact with any other person with similar illness?

○ Yes ○ No ○ Unknown

_____

If Yes, specify

___ / ___ / ___

Date of contact

Section 5. Comments/Follow-up

Comments:

_____

Investigator Name

_____

Agency

___ - ___ - ____ ___ / ___ / ___

Phone Number **Date**